SAMHSA's Center for the Application of Prevention Technologies (CAPT)

Addressing the Nonmedical Use of Prescription Drugs: Unique SPF Challenges (Steps 1-3)

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[Michelle Frye-Spray]: Hello, and welcome to our webinar. We will be getting started. Please, as you're coming into the room, answer the chat questions that we have up. We are really looking forward to hearing from you, learning about whether or not this is your first time working with a grant to address the nonmedical use of prescription drugs, as well as: what do you hope to get out of today's call?

We'll be getting started here momentarily with the webinar. We want to give you an opportunity to answer the chat or our poll questions as you come into the lobby room. There are two poll questions.

And I see one person has responded. And it looks like this is your first time working on a grant to address the nonmedical use of prescription drugs. And I'm sure this is going to be a common theme as we're moving through the webinar today.

My name is Michelle Frye-Spray, and I'll be facilitating your process today. If you haven't done so already, can you go ahead and please mute your phone lines? The phone lines will be open for discussion today, but we would like to have you go ahead and mute your line by pressing the *# to mute and unmute.

I see we have a few more people who have joined the room. And it looks like we still have a lot of people who are having this as their first-time experience working with the nonmedical use of prescription drugs in terms of preventing.

We'll be getting started here at the top of the hour. We're very pleased that you've

joined today's call. We have some very informative presentations today, both some peer sharing as well as some content on the first three steps of the SPF.

As you're coming into the lobby, please go ahead and fill out the lobby poll. And we're at about 50 here with those who have had experience with addressing nonmedical use of prescription drugs. And I see some people are starting to type in the chat box here. What would you like to get out of today's call? We would love to hear some initial thoughts/expectations that you might have for today's call, and you can put that on the right-hand side of the chat box.

Hey—very interesting expectations.

"I would like to see how this would tie into my past SPF SIG work and the current PFS, as well as strategies for projects, lessons about how to make connections and collaborations."

Yes, I think we'll get into both of those expectations.

And we have "looking for additional information on how to tie into current PFS and strategies for other prevention providers."

Maybe tying into some of those nontraditional prevention providers that we normally don't get to, I suspect, Tiffany.

We'll go ahead and get started here in just a moment, but until we do, please go ahead and put your expectations down.

And we also have an expectation that "since the number of evidence-based strategies is limited, any resources on promising practices."

Yes, we do have some decision-support tools that have been developed in partnership with the CAPT and under the CAPT. So, we'll be definitely sharing how you can access those. And it looks like we have still a few more people who have had some experience now addressing the prevention of nonmedical use of prescription drugs. And so, we're going to be interested in hearing about some of your lessons learned, as well as challenges and successes for the topic.

So, I think we're at the top of the hour, if we would like to go ahead and move from our lobby into the actual presentation.

Again, I'm Michelle Frye-Spray, and today, we are going to be covering the topic of addressing nonmedical use of prescription drugs: some of the unique challenges of the Strategic Prevention Framework that are presented through addressing this topic and how we can use our framework Steps 1-3, and some of the lessons learned from

the past to make some inroads to reducing the nonmedical use of prescription drugs.

So, we're pleased to have you today, and we welcome your contributions through this process.

Again, I'm Michelle Frye-Spray, and I am pleased to be your facilitator today. I'm responsible for coordinating—assisting with the coordination of services—for the CAPT West Resource Team, and we work with 11 states, six pacific jurisdictions, and six tribes within the CAPT West Region.

The objectives for our webinar today are to really help you identify some examples of challenges associated with the nonmedical use of prescription drugs in the first three steps of the Strategic Prevention Framework. We want to help you look at not only the challenges, but also some of the solutions to overcoming the challenges that you're starting to experience and your grantees might already be starting to experience as you anticipate their writing for their applications.

We also want you to be able to describe some of the approaches that other grantees have taken, and be able to help translate those to some of your subrecipients' needs. And we want you to be able to walk away from today's experience with a few tools in your toolbox and knowing where to come back to get some further technical assistance.

So, we are going to be introducing and providing an overview of preventing nonmedical use of prescription drugs. We're going to look at those local obstacles in the Strategic Prevention Framework, steps 1-3, for addressing this topic. And then we're going to also provide some opportunities for peer sharing and discussion.

So again, we're welcoming you to participate in this interactive dialogue. We have a lot of content to get through today, and so we're going to be keeping a pretty fast clip. But we do want you to feel free to open up your phone line and chat box during the discussion period.

Without further ado, I'm going to go ahead and introduce Dr. John Carnevale. Dr. Carnevale is president of Carnevale Associates. It's a public policy consulting firm that conducts strategic planning performance measurement and management, and policy and program evaluation, for a range of both public and private sectors. Prior to becoming the president of Carnevale Associates, LLC, Dr. Carnevale worked for 18 years in federal government service, where he was employed as an economist with the executive branch. Dr. Carnevale served for 11 years at the White House Office of National Drug Control Policy as the director of planning, budget, research, and evaluation, working under three administrations and four drug czars to shape national drug-control policy. Dr. Carnevale directed the formulation of numerous national drug-

control strategies and federal drug-control budgets. Dr. Carnevale holds a bachelor's degree in economics from the University of Maine and a doctorate in public finance economics from the Maxwell School at Syracuse University.

So, we are very pleased to have Dr. Carnevale sharing his expertise with us today, and I will now turn it over to him.

[Dr. John Carnevale]: Thanks, Michelle. And welcome, everybody. And with that introduction, Michelle, I guess everybody knows I must be getting kind of old. I have really long experience in dealing with U.S. drug policy and working on various topics, including SPF SIGs.

My charge right now is to sort of provide some general background, some information that we can all use as we go through the rest of the webinar about the issue of prescription drug abuse. This slide that we're looking at right now is just to start to give us some common definition that we can use in talking about what's commonly called *nonmedical use of prescription drugs*.

The one point that we all like to make when we talk about this is that there really isn't a standard definition that everybody uses when we talk about these two terms that are in front of you: the *nonmedical use of prescription drugs*, or *drug misuse* in terms of prescription drugs. But they tend to be driven by the NSDUH survey.

So, the national survey on drug use and health (NSDUH), conducted by SAMHSA, collects data on what it calls nonmedical use of prescription drugs. And the definition in that pink area, in terms of what's there, represents, essentially, the definition from that survey.

So, in talking about this, in the rest of this presentation, we'll be talking about nonmedical use of prescription drugs, but just keep in mind that there is sort of a large language here that people use.

In the old days—and I'm talking back in the 90s and when we went to Europe and people talked about drug misuse. Back then, a lot of those places we used to visit had harm-reduction policies, and the use of the term *use* was misused—kind of unacceptable in the United States—because it implies use is OK; it's misuse that's the problem.

So, over a couple of decades, I think we finally settled on what we mean by that term as it's described here in terms of intentional or unintentional use contrary to direction. So again, it's getting at the point that we really don't have a common definition for what we use to describe prescription drug abuse. But you'll see in the literature a lot of reference to nonmedical use. And that's the term we'll be using here today.

Now, when we talk about prescription drugs, there's a vast category. Right now, everybody's hearing from the media a lot about opioids—and for good reason. It's obviously a clear problem, as with pain meds and so on.

But these are sort of the types of categories that we tend to focus on in terms of prescription drug abuse. These four categories that we have, with opioids being the most prominent right now, are usually prescribed for pain relief, and you see the categories of drugs below: there's more, of course, that are examples.

These are all schedule drugs, of course. Stimulants: they tend to be used for attention-deficit issues, and they can be abused. We'll talk a little bit more about that later on. Then there is the category of tranquilizers. And then, of course, we have sedatives.

And as I said earlier, a lot of the discussion that's going on in the United States is really focused on the first area, but that doesn't mean that when we explore what's going on with your grantees or in your states, and when you explore the issue of nonmedical use of prescription drugs, that you should only be thinking about that first column. It's all of the above, so to speak, in terms of the kinds of drugs that you would be considering when you go into your communities to see what's going on with the various types of prescription drugs being abused.

So, in terms of just a few stats—and we can give a lot of background, and we chose not to—in terms of the major extent of the prescription drug epidemic, as it's sometimes called. We just want to give some highlights.

This slide shows the sort of rates of prescription drug abuse in the United States—and this is based on people who report having used a prescription drug non-medically in the past year. So the question is asked, "In the past year, did you use any one of the following drugs?"

And they'll answer "yes" or "no." And then there are follow-up questions.

So, you can see from this one, in the slide the first bullet, 4 percent of adults and almost 5 percent of youth in the U.S. use pain meds, in this case nonmedical. And in terms of overall illicit drug use—the second bullet—you see that almost 10 percent of adults and youth use illicit drugs.

Now, when you look at illicit drugs, you'll find that most of that tends to be marijuana, the way the household survey works. I went back and also looked at the most recent household survey, and it reports that about 15 million people age 12 and older used prescription drugs non-medically in the past year. And 6.5 million use them on what we call a current and regular basis: in other words, in the past month. So, that gives you a sense of how large this problem is.

In terms of one area, when you talk about consequences—and there's many areas/ categories of drug-use consequences. Here we're looking at treatment admissions and what's called a treatment episode data set.

This is our data system of SAMHSA; you can tap into it. The data from—it's called TEDS. The data from TEDS tend to be available with quite a lag. I think really the most current data that's out there in terms of trends for most data go up to about 2013. But the most complete data were 2011.

So, at least we pulled that out to give you a sense of treatment admissions. And here you can see the rate. There are seven individuals per 100,000, which is the rate of who are admitted for treatment for primary non-heroin opioid use—in other words, things like pain meds.

And about 105 individuals per 100,000 were admitted for heroin use. So, you may know that heroin is a growing problem. So anyway, that's the issue in terms of treatment. There's a whole other world of consequences that tend to make the media, and we're trying to collect data on nationally how you deal with things like drugged driving—specifically drugged driving. And that's an area that's also—we're starting to get data from traffic fatalities in the United States that can give us a sense of this problem.

And the next slide I want to get to is sort of the introduction now of what we're going to be doing today. So our focus here is really on the nonmedical use of prescription drugs. And we're going to look at it in terms of the first three steps of this process, having to do with assessing needs, building capacity, and developing a strategic plan. So we're going to start next with Step 1 of this process, having to do with the needs assessment.

So, Step 1—and I'm assuming everybody's familiar with this SPF process, but we're going to get into it in a little bit more detail today—has to do with assessment. Here, this is the step where prevention professionals get together and get data from their local communities, or from states, or other places to come up with a needs assessment or a problem assessment that they can use to figure out how to develop their policies. So, you have local sources you can go to, like youth surveys, prescription drug monitoring programs. We'll talk about that more later—local universities and so forth.

The key thing that's important here is that assessment process. We like to see decisions about programming of interventions being data-driven. In a perfect world, we would have all the data we need to make good decisions about interventions. But the reality is sometimes decisions are data-informed, where we don't have quite enough information, but we can use knowledge about the problem locally to come up with a

solution.

So, this next slide is one that SAMHSA, in terms of doing the needs assessment, they like us to think about risk and protective factors in terms of what's called the socio-ecological model. This model is fun to look at, to watch audiences look at it, because everybody starts turning their heads from left to right because of the way the typing goes on this. But essentially, it's a model that says there are sort of four levels in terms of behavioral health problems that we address, which includes mental health conditions and substance abuse. And it starts at the center with this individual, and it works its way out to the family, the community, and to the society at large.

So, let's now consider the challenges to this whole assessment process that are commonly faced. Here we have the big issue—usually has to do with simply coming up with a way to assess data sources to figure out what we have for information. Since we're talking about prescription drug abuse, one source we have here is state data having to do with prescription drug monitoring programs—a great resource. But in terms of the challenges, getting access to that information can be difficult. There needs to be some support to providers and to grant recipients about that. And they also may need help in conducting with the surveys and just simply getting familiar with the whole literature in the world of risk and protective factors.

At this point, I'll turn it back to Michelle.

[Michelle Frye-Spray]: Thank you, John. We have a poll for you to kind of uncover some of the challenges that you see as being the most difficult for your grantees in Step 1 as you're moving into addressing nonmedical use of prescription drugs. I know a lot of you have had experience, and your grantees have had experience with alcohol, underage drinking, binge drinking among 18- to 25-year-olds.

And so, it really takes a lot of work to begin to make this transition, and in terms of what data sources do you begin to even look at, and how do you begin to build some of those relationships and help your local grantees to do that?

So, the reflection of some of the challenges that John has just kind of tapped into are showing in the poll as accessing existing data sources, knowing what they are. How do you begin to collect, to analyze? How do you begin to build your capacity, to analyze local assessment data . . . and then, followed by conducting local assessments.

So, if you have any other areas, you can go ahead and type those into the right-hand side for other challenges. Or you can put those into the regular chat, as well, if you want to speak to those. And we have one person who seems to be typing into the chat box.

So, John, do any of these surprise you in terms of the responses that we've gotten so far?

[Dr. John Carnevale]: Not at all. No. Especially assessing existing data sources. That's one I see commonly in terms of what communities run into. They simply don't know where to go, in terms of getting access to maybe local area information. And we can talk more about that.

[Michelle Frye-Spray]: Yes. And we will talk more about that. And we're starting to run out of a little bit of time for this section. But Ellen has mentioned that adult data is more difficult to get than youth data.

And then Michelle: "Working with Indian Health Services on getting data from pharmacies and ER visits."

So, continue typing your information in a chat box or in this chat box, and then we can transfer it over potentially as we move forward in our discussion.

All right. So, we're going to move on and, John, I'm turning it back to you.

[Dr. John Carnevale]: OK, thanks, Michelle. So we've talked about the general challenges, and we've talked about the issue around assessments of local data, and that is a very common one. In this—in the next slide, we're going to talk more about some common solutions to these challenges.

And generally, the solution that is most popular is something you go out and develop relationships with local grantees and organizations. So, in this area, given that we're talking about nonmedical use of prescription drugs, we've highlighted in here this thing called PDMP, which is a prescription-drug monitoring program.

So, in terms of fostering relationships, one area that we're encouraging is to reach out to your state. I believe all states but Missouri have a PDMP, and they can be a great source of information that can be used locally. And we can talk a little bit more about that later, as well.

So, helping them get linked to these various organizations that may have external sources of data that relate to a community is very important. Just in addition to sort of the fostering of relationships, you also have other local resources in most cases. Tapping into local colleges and universities, you can get a lot of technical assistance to analyze the data that you have. Again, we have access to—but it's a very powerful resource—you'll find at a lot of schools people who are very happy to help you analyze your data for all kinds of reasons, because you're part of the community. And so we encourage that.

So, in terms of the other part of this, there's a lot of technical assistance and support tools that are available from the CAPT that you should also look toward to get some really good advice on how to make these connections and to foster these relationships that we talked about.

So, to keep us on track here, let me know when to turn it back to Michelle, who will introduce our first case study. Michelle?

[Michelle Frye-Spray]: Thank you. Yes, we have Kristi Allen, who is the director of programs for the C.A.R.E. Consulting Group, who is going to be speaking today on behalf of the Cherokee Nation. C.A.R.E. is providing the evaluation services for the Cherokee Nation PFS Project and has been working directly with the Cherokee Nation and each of their 11 subrecipients across 14 counties.

So, Kristi, are you on the line? So, we'll give you a moment to connect with the group.

So, John, I'm not sure if you'd like to go ahead and just talk about a few more—go a little deeper with some of these challenges and simple solutions while we're waiting.

[Dr. John Carnevale]: Sure. Let me go back. Put those slides back up in front of everybody.

Let's see, we talked a little bit about PDMP programs. And they're a great resource in terms of what's going on with prescribing behavior in your communities. And just to let you know, there will be a webinar coming up at the end of next month on this very topic of how to access your PDMP data. It does tell you a lot about what's going on in terms of prescribing in your community. And then you can do things related to overdose information and emergency room data in your community, as well.

And in terms of the prevention role that you're in, when you start to facilitate relationships, it gives you a clue about where you should then go to talk to various groups in terms of local assessment challenges.

So, that's one area that we do emphasize. The second area has to do—let me go back to the next slide—we talked about colleges and universities. And there is a lot of training for grantees that can be found at the CAPT website that we've talked about. And we'll highlight some new tools that are going to be coming out in May towards the end of the webinar that you'll, I think, find very valuable as you try to work through the basic assessment process of Step 1. Michelle—go ahead.

[Michelle Frye-Spray]: I do think that we're still trying to work through some of the technical issues for Kristi to share.

But I'm just wondering … I know that some of the real challenge is: how do you begin

to use that data through the monitoring programs? And I'm really hoping that we can get down to some specific examples of how different states are beginning to use that for prevention, because I think it's just a very different mindset.

[Dr. John Carnevale]: Well, I can give an example while we're waiting—and we did a couple of years ago in Massachusetts—we had a study with Brandeis for CSAP. And we were able to take state data from Massachusetts and look at prescribing behavior of pain medications down to the zip code level. And then we identified, after controlling for pain med clinics—which is something we economists like to do is control for various kinds of complicated things—we were able to find areas where we could find what we would consider to be overprescribing, and correlate that to problems where we saw people showing up and presenting for treatment with problems from pain medications where either there were a number of overdoses, where the emergency rooms were showing, you know, real problems.

And so, this became information for the local prevention community, because they then could say, "Aha. We've got an issue here with prescribing. Maybe we should go out and start talking to the doctors in the community about—when you go to the dentist or the doctor, instead of giving a prescription for 30 or 40 Vicodin or Percocet, where you only need three days' worth, explaining to them that they're actually contributing to a real problem."

So, it was a way to alert the local prevention community about a problem. Likewise, we've made a valuable tool . . . go ahead.

[Michelle Frye-Spray]: Excuse me. I'm going to cut in here because I actually think Fernando is going to speak to maybe some of that in Massachusetts later.

[Dr. John Carnevale]: OK. Good.

[Michelle Frye-Spray]: So, he'll kind of give us the next step to some of that work. And then, I'm hoping that we're going to be able to connect with Kristi now.

[Kristi Allen]: I think I'm on. Can you hear me now?

[Michelle Frye-Spray]: Yes, we can hear you.

[Kristi Allen]: OK. They unmuted my number. So, you just tell me when. I can wait for Fernando.

[Michelle Frye-Spray]: Oh, actually Fernando's going to be later in the presentation. So, we welcome you to go ahead and get started, Kristi.

[Kristi Allen]: OK, great. Sorry about that. We had a very efficient mute system.

OK, so, real quick. So, the Cherokee Nation Project has 11 subrecipients. And one of the key factors to remember about Cherokee Nation is that it's not a reservation or any type of isolated type community. The majority of Cherokee reside within communities that would resemble your average American small towns, with a few of them in our particular project here being more mid-size than small. Since the jurisdiction is shared between the Cherokee Nation and the state and local government of these communities, we're really forced to have a very high level of collaboration between the two entities. The sub-recipients work very closely with both sets of authorities.

That does represent a challenge, in that they have to learn more than one system and learn how to navigate through multiple systems: both state systems, local systems, as well as the various tribal systems. So, it calls for a lot of communication between our subgrants, our subrecipients, and their community stakeholders, and lots of cultural considerations there. For our tribal epi work group, we are working very closely with the state of Oklahoma and looking to combine our efforts and our meetings, since a lot of times it's really the same people around the table in these efforts.

So—and because of the geographical issues, we're looking a lot into doing these through virtual meetings, like Adobe Connect and things like that, so that we can increase attendance. Getting local prescription drug data—Oklahoma has a new—within the last year, it now has a mandatory PDMP, which is real-time, which is fantastic.

But since it's such a new system, the communities do not yet know how to access the information. So, that's one of the key objectives of the tribal epi workgroup working with the state epi workgroup, is we're trying to develop a system of data sharing that will streamline the flow of information from the state gatekeeper of this PDMP data and our communities.

And what we're really trying to eliminate is that gatekeeper being inundated with, say, 50 data requests the week before a lot of various reports or things like that are due. So, we're trying to come up with a proactive plan for a type of annual data report that the epi work group can work on and provide to the communities on a regular basis.

So, I think that's kind of like our challenge and our potential solution that we're working on with that, with it being a new system. Because our groups are essentially all working on the same strategies, one of the key things that we've developed recently is, of our 11 subrecipients, they've created six strategy workgroups. And so they're working collaboratively.

The 11 different coalitions are working to build the implementation plans for their six key strategies together. And this will be a plan that each community can use as the foundation for their implementation plan. So, they all have input on all the different

plans, but then they also—once they take it back to their individual coalition, they just kind of put their own little cultural tweaks and modify it for their specific community.

But what's great about that is that we're learning that they're really learning to share resources—leverage their resources. A lot of them need the same materials, and supports, and types of technical assistance to implement. And so, we're finding ways to kind of streamline that process.

So, I'm sorry, that's a lot of information in a short period of time. But I think that's all I have.

[Michelle Frye-Spray]: That was great, Kristi. Thank you so much. You know, some key words that I really appreciate from your sharing is that it's a proactive process that you're developing there with your PDMP data, and trying to think ahead as well as working with your grantees to share and leverage resources. And that really takes us into the capacity building.

And, I'm going to turn it back over to John.

[Dr. John Carnevale]: OK. Thanks, Michelle. And so, the second step of the SPF process has to do with building capacity. So in approaching this, we're going to follow the same format we did before. We're going to start a little background and really start thinking about the challenges that you face in building capacity, and then come up with some common solutions. So, in this case, we see, I think the first bullet really highlights the most important part, I think, which is really to survey the communities' awareness of the problem. That's one aspect of it.

You'll often find, in terms of various participants in various parts of your community, that people simply don't understand or they're unaware of the nature and extent of the problem. That's one. Two—is there is a lot of literature on sort of this thing called *community readiness*, where you look at the assets in the community in terms of your ability to engage or deliver services. And knowing that is, I think, critical after the assessment process, where you've spent time really thinking hard about the problem after getting as much data as you can to describe it. And then you start to formulate sort of some solutions in terms of where you want to go. But to go down that path, you have to then sort of figure out, well, what's your capability of delivering services? And so, this capacity building step is very important.

Next slide.

So here, as the slide shows, one way you can help communities build capacity is to work with them to strengthen their prevention workforce. You can help them identify external resources. And you can also make better use of existing resources. That's

really the theme here—thinking about what you have and what you—in terms of local resources and how you can make better use of that. And then, if you're providing support to subrecipients in your programs, really identifying other funding opportunities that might complement the resources that you're getting from grants.

So here, we talk about in-kind donations, volunteers, and so on. This is also part of this theme from earlier, in Step 1, in the assessment, where we start talking about sort of fostering relationships in terms of SPF goes hand-in-hand with that. So now, the potential challenges that we tend to face in this area is we're unaware of the nontraditional stakeholders in what I'll call my *old days* when I go to meetings in the community and we bring in people to talk about the data assessments. We always meet the sort of same people sort of throughout the whole 5-step process in the SPF process.

But we would say things like, "Well, have you talked to [in this case is we're dealing with nonmedical use of prescription drugs] . . . dentists and veterinarians are important. They prescribe. And they are often forgotten as potential contributors to an oversupply [in this case we'll say] of pain medications or stimulants in their local community."

So, bringing them in raises their awareness in terms of the problem, but also adds to the issues around capacity, because they suddenly are aware and they will understand that, by changing some of their practices, they can be helping the community at large. So that challenge is simply identifying the nontraditional stakeholders. I often add, because I also have a budget background from the Office of Management and Budget, —the *budget geek*, as they say—I always find it valuable to bring in your local budget person who works the city council budget—budgets the mayor—because they know where all the money is. And I also think that they're often forgotten, and they can be quite a resource.

So, in this next slide, we continue to look at some of the potential challenges. And here you can help subrecipients build capacity through activities like action planning. That's the middle bullet. Action planning is really thinking about, "OK, we've got shortages and problems with our community readiness," or "We've identified gaps."

Well, then you have to ask the question, "What are you going to do about it?"

And sort of action planning can help you strengthen your community assets and make them more functional, more useful, and build community readiness. So, I think at this point, I want to turn it back to Michelle, so we can hear more from you in terms of what you understand to be challenges in your community.

[Michelle Frye-Spray]: Great. Thank you so much, John. So, out of the challenges

that John has listed, we have created just some big-picture challenges that you might be experiencing or your grantees might experience in Step 2.

Which ones do you feel are going to be your greatest challenges? If you can just complete the poll for us, it will guide our discussion as we move forward.

Again, difficulty in engaging stakeholders is really right out front, followed by challenges determining existing community readiness. And that really does, I think, you know, weave into the issue of engaging our stakeholders: the readiness issue.

And then looking at challenges developing an implementation action plan, as well as being unaware of nontraditional stakeholders. I think that we've mentioned most of these.

And we've got some people typing in some other challenges. Please feel free to do so.

I was thinking that, you know, really engaging the dentists as well as the physicians is challenging, because so often we know that they're busy people, their offices are busy, and how do you really navigate their schedules and get to what they care about? It's the *what's in it for them* that can sometimes be difficult for us in prevention and really developing those prevention pitches that we know, you know, we need to tailor to our audience.

So, I think that's one of the areas that we're really trying to home in on is: what are the prevention pitches specific to this issue and the stakeholders that we can use?

Please feel free to put your information into the chat box.

And then we also have Michelle discussing past experiences in the SPF SIG. There were also difficulties engaging stakeholders.

Well, hopefully you had some challenges there, but some lessons learned that will transfer over to the nonmedical use of prescription drug issue as well. And you probably made some real inroads with that. But it takes time, and there are no easy solutions, we know.

So let's see, yes. Lessons learned. And it will help that it's a new topic to address. Oh, good.

So maybe there is some burnout in your community from addressing, perhaps, underage drinking and them feeling like, "Oh, we're already done. We've done this."

All right. So, let's move back to the presentation, if there's no further discussion.

Oh, it looks like Tim has some information in here.

In the chat, John, it says “I have been looking at the literature to see if there are validated methods that abbreviate the community readiness methods, but are still validated results—or still get validated results. I’m wondering if the CAPT has any additional information on this topic.”

Or, John, if you know, if you can speak to this information, as well, I’m sure Tim would appreciate that.

[Dr. John Carnevale]: OK.

[Michelle Frye-Spray]: And then it looks like Molly is also responding.

[Dr. John Carnevale]: OK. I’ll jump in, then. So, yes, engaging stakeholders is a big challenge. We all understand that. And there is, I think, a very rich literature available. There are a lot of tools generally about SPF SIG, not necessarily dealing with this particular aspect of the drug problem, but the core approaches are usually the same. You know, how do we get engaged? How do we get the people who are very busy to come to a meeting so they can get understanding?

And often you can do things like work with your media as a starting point. And depending on how large a community you’re defining, I think it’s important to find some of the charismatic people in the community who can go knock on doors and get people to come to meetings to talk about problems.

But—and there’s a lot of things that can be done. Again, these tools are available to you. And we’ll highlight some in a few minutes. I’ve said that earlier. Drumroll when we get to that slide …

In terms of community readiness, there’s some literature going back about 20 years on this—at least that’s when I started reading it—about how to sort of strengthen the assets in the community that you have. And I think it’s pretty extensive, and the toolboxes that are available on this are, I think, quite good.

And I’m not sure if there’s any way to sort of shortcut the process that we all have to go through in terms of assessing assets. But again, we keep thinking about people who are prescribing locally. You also have pain clinics and things like that. And they tend to be more approachable because they are part of the medical world, and the health care world is paying attention to what they’re doing. So they might be more receptive to being approached to talk about what they’re doing and how they can be assets in the community when supporting the problem or addressing the problem that we see.

So, in terms of the community readiness model itself, here we’re really trying to find out, in terms of addressing the problem, identifying the assessment, you know, what

the community's ability is to respond to that problem. And part of it may be simply going about the community and trying to find out what resources really can be committed to address the problem.

And that's why I always like to bring in some of the budget folks in the community who make decisions on resource allocation. Pressure can be brought to bear through, again, using the local media, getting people who are community leaders to start talking about this, raising awareness. There are all these approaches that are a lot of work. But that's what has to be done, I think, in terms of getting assets lined up to help with the issue of, sort of, program delivery.

And we keep having this reference to action planning in our slides. Action planning is, once you get a problem identified—and in the case of community readiness, it may be substantial—you pick the things that are most important, and you come up with a plan or a series of action steps that you're going to follow to try to involve people that you are trying to involve, in terms of the difficulty to reach stakeholders.

I guess what I'm saying is it's not as easy as it sounds; it's a lot of work, but you can learn from the experience from others who have done this. And there are a lot of resources to help you through this.

So, in this case, in terms of your grantees, one thing that's important is connecting the subgroup recipients to those with SPF experience dealing with nonmedical use of prescription drugs. We saw in the beginning of the call that some of you have had experience dealing with this topic of prescription drug abuse in the communities. And what the state can do is get that list of people and get them engaged in conversations to talk about, "Well, here's what we had in our community as a problem, from our assessment. And here's how we identified some of the assets we had. And what did you do? And how did you get the dentists to show up to a meeting, to at least start talking about their prescribing practices?"

Those are things that I think are invaluable, in the sense it's about communication. So, you know, this slide, I think, essentially says, you know, "Look to other grantees to learn from their experience."

And you can probably get a lot more from that and save yourself a lot of time and frustration by doing that. And again, we go back to the idea of identifying other existing training and expert resources. Having a list of those, certainly at a state level, like resources—people who might be experts and available to communities—is useful.

So, when we talked about the prescription drug monitoring program, I think it's important at the state level how these programs or PDMPs are state-based, that they be approached. I'm talking in terms of what we just heard as an example, where they

put out reports, mainly that helps all grantees locally on the data assessment. That's a great idea.

So doing things like that, I think, is very important. You can help facilitate, sort of, contacts with the difficult-to-reach individuals and stakeholders who need to be part of the solution when you're going through the SPF—going through this particular SPF. I believe, at this point, I'm supposed to stop and—here, Michelle, I'll turn it back to you.

[Michelle Frye-Spray]: Thank you, John. So, actually, I have a question for you. And it looks like we have a question in the chat box as well.

And if we have people from Michigan, please feel free to kind of raise your hand, and we really would love to hear about some of your experiences there in Michigan. Our presenters today—I don't think they quite made it on the line this afternoon. But so we have participants, feel free to raise your hand and put it into the chat box. It looks like, ah, Michigan is here. Excellent. Excellent.

But in the meantime, let's move to Michelle's question, or her response here. She says, "I'm thinking out loud here. My community's located within a county that's comprised of two Indian reservations: the Winnebago and Omaha. From a data standpoint in the assessment phase, we will essentially be collecting half of the local resources. We have people crossing reservation boundaries, whether it be to obtain prescriptions or illegal activities."

Interesting, Michelle. So, I'm wondering if you have some specific questions that you can put out to John here in a moment. And while you're kind of thinking out loud and articulating maybe some more questions, we're going to go ahead and turn it over to Michigan and ask them to go ahead and share out. And if you can also give us your name, let us know who's on the line.

[Larry Scott]: Yes, this is Larry Scott. Could you hear us?

[Michelle Frye-Spray]: Yes, we can, Mr. Scott.

[Larry Scott]: Yes. We have been very fortunate to have both the Partnership for Success II and the current Partnership for Success 2015 grants regarding capacity-building challenges and solutions.

Keep in mind that our subrecipients for our Partnership for Success 2015 grant are engaging the medical community, based upon their level of prevention preparedness or their level of community readiness to address nonmedical use of prescription drugs.

Now, we based the level of community readiness on the drafting model, on readiness to change. And so our subrecipient communities are rated on three levels: Level 1,

they're not necessarily a prevention-prepared community. In other words, they're not necessarily prevention-prepared—but they have a coalition—but there's no engagement with primary care. Level 2 would be a subrecipient community that is a prevention-prepared community. They have a coalition, but they have minimal engagement with primary care. And the Level 3 community would be a subrecipient community that would have a strong prevention-prepared community, or strong in terms of prevention-preparedness—would also have a very strong coalition or group of coalitions, and would have active engagement with primary care.

And so, to augment the levels of preparedness, for Level 1, we instituted, or, I should say, we provided the Communities That Care training, as well as training on Communities Mobilizing For Change. For Level 2 communities, we provided the Communities That Care and Communities Mobilizing For Change training, as well as training on prevention evidence-based practices, such as Strengthening Families, Prime for Life, and Active Parenting of Teens. And for Level 3 communities, we provided training on evidence-based practices on all of the above, and we trained all levels, all the community levels on SBIRT.

And so, a prevention-prepared community is a community that is—they have the capacity to actually implement all five steps of the SPF SIG. So, that's how we rated the communities in terms of level of readiness. And obviously, based on their level of readiness, they had varying challenges pertaining to capacity building.

So, some of the approaches and strategies that we use to build relationships or to promote engagement within the communities included engaging all the parties, including primary care, and coalitions, and the CTC training and training in SBIRT.

And most importantly, it's really, quite frankly, it's incumbent upon communities, subrecipient communities, to emphasize a win/win for all parties. In other words, what's in it for the primary care community to be involved in the nonmedical use of prescription drug prevention? What is the win/win for the coalition? What is the win/win for the SSA community, as well?

For example, for primary care, if they're a nonprofit entity, such as a Federally Qualified Health Center, or another hospital or primary care agency, they actually have to apply every three years to retain their nonprofit status to the IRS. In their capacity to retain a nonprofit status, they must actually engage the community in developing a community plan for addressing primary care within that catchment community.

So, the win is for them to participate in the project in the provision of nonmedical use of prescription drugs. And the win for the coalition is to engage the primary care agency in that implementation and prevention process. Actually, it's a win/win for both agencies.

[Michelle Frye-Spray]: Wow.

[Larry Scott]: I'm sorry?

[Michelle Frye-Spray]: I said, "Wow," Larry. That's so interesting. I'm just wondering how long has it taken you to really lay that foundation with your primary care? And did you do that in anticipation of addressing nonmedical use of prescription drugs? Or was it to address a broader capacity-building issue?

[Larry Scott]: We developed our brand, which is provision for (care) communities, about four years ago. And that came about as a result of our office providing prevention treatment and recovery in a recovery-oriented system of care context. And so, we wanted to be able to persuade our prevention field that prevention has a role in a recovery system of care. A prevention-prepared community is a key pillar, if you will—a key component within a recovery-oriented system of care.

And so, in order for a recovery-oriented system of care to work at peak efficiency, then you must be able to implement all five steps of the SPF SIG process, which is, quite frankly, a business model in how you actually provide prevention services. And so, we've been able to incorporate that statewide in all of our regions—all of our administrative regions—for substance abuse prevention and treatment for about four years. That put us in a position to secure a Partnership for Success II grant, which allowed us to develop relationships with primary care entities.

That carried over, if you will, to the Partnership for Success 2015 grant project. We were able to—based upon our epidemiological study, we were able to, if you will—glean from some of the subrecipient communities that were participants in the Partnership for Success II project. Those communities are what we would consider Level 1 communities or Level 2 communities, where they've developed some interaction—successful interaction, if you will—with primary care, based upon their Partnership for Success II initiative and based upon, if you will, their success in building a prevention-prepared community.

[Michelle Frye-Spray]: Very interesting. I hear a lot of really key components about not only capacity building but also how that connects with sustainability across the entire continuum of care. And being able to build a pitch to those key stakeholders that maybe those communities have not worked with before, such as primary care, and what a long road that is to build that solid foundation.

[Larry Scott]: Absolutely.

[Michelle Frye-Spray]: Very interesting work. And it's like each of the grantees has to do it in a very different way, right? Each of our states has a very unique context, and

the local communities, as well.

So, if anyone has any specific questions for the Cherokee Nation or Michigan, please put those in the chat box.

And, do you have any last remarks that you would like to share, Larry, before we turn this back over to the participants?

[Larry Scott]: I would only suggest—and this is really key—that primary prevention and primary care—those are two different cultures, and they operate with two different languages. And oftentimes, you have to convince—or, I should say, persuade—primary care to think about prevention, not as a preventive type of activity, but a primary prevention activity. They tend to use an acute care model in treating chronic illness or issues like overdose, for example, or prescription drug overdose, or heroin overdose. They don't necessarily treat it. And I understand they don't necessarily treat it with a primary prevention or even a secondary prevention approach.

So, I think that grantees need to be patient and understand that it's going to take a period of time to learn the language, to learn the culture, and to be able to create that win/win situation based upon that knowledge, and to build upon the preparedness in your community.

[Michelle Frye-Spray]: Wow. Yes. You know, that whole idea of it truly is—we use this a lot—but it's a paradigm shift, isn't it?

I know that I just got back from the prescription drug summit in Atlanta, and what I was really struck by was, you know, it's great that we're beginning to address the nonmedical use of prescription drug issue and how far it is up the stream. And how do we, as prevention people, get this effort moving further up the stream and so far down the stream in terms of treatment? And I think we have a long way to go. How do we craft our language to really move people towards, you know, prevention strategy?

[Larry Scott]: Correct.

[Michelle Frye-Spray]: And then, working with our primary care: yes, that's another area of having to craft, you know, retailor conversations.

So, any questions or comments that anyone may have for Larry, or that, Larry, you would like to make?

And if not, we're going to move into questions from participants related to capacity building. We'd love for you to put your responses to these two questions in the chat.

Some of the experiences you've had assisting your local grantees in addressing

nonmedical use of prescription drugs during capacity building: what's been particularly successful, or less so?

And thank you so much, Larry, for being on the call today and sharing with us.

So, as we have people typing, we are going to just give you another minute or so to do that. And I know many of you—you're really just starting up. And so, I think the message here is that it does take a lot to lay the foundation to address—to begin to build your partners and a context for prevention related to the nonmedical use of prescription drugs. So if it's OK, I would like to go ahead and move us back to John's presentation on Step 3.

[Dr. John Carnevale]: OK, thanks, Michelle. And Larry, thank you. That was really interesting, I thought, when you talked about sort of connecting the primary care providers to the prevention community—talk about a nontraditional stakeholder in today's world.

The primary care community, as you said, which operates under the acute care model, sometimes doesn't think about prevention in terms of what we are used to. And in the Affordable Care Act and so on, it does. It's a real opportunity now to sort of connect those two groups or the two dots, so to speak, in terms of thinking about capacity at the local level. And the way you sort of organized and characterized local capacity in terms of your levels and so on, I think, is valuable experience that everybody can draw from.

So, thank you for that. OK, we'll get to the slide. Here we go.

So, I'm now going to start talking about the third step of the SPF process, having to do with the planning process itself.

Now with this slide, we have sort of three boxes at the top. And I'm going to spend a little time on this one probably, and a couple of more ahead. But the planning process now becomes very important: it's going to be informed by the assessment that you've done at the local level, in terms of using all the information you can access and using the assets in your community to sort of manage that information and to think about connecting this. Larry did in Michigan—the dots with various groups and organizations.

And we start to move forward to solutions. Here, we had the issues around problems, and it then became really about thinking about, moving left to right, the assessment process.

And so, in the planning process, you've done this, you've thought about the nonmedical use of prescription drugs and related programs. And now, you're starting to think, well, OK, we've identified certain populations, perhaps, or issues that have to

be addressed because of the problem. And we'll talk more on that, as an example, in a couple slides.

Under the risk and protective factors, we talked about that ecological model that's available. It really helps identify many risk and protective factors that can be evaluated, and there are many tools to do that. And here—so under the risk and protective factor section, we're going to be thinking about assessing the factors in terms of risk. And all of this is designed to move us towards planning for an intervention that is informed, at least, by data.

Remember in the beginning we talked about data-driven versus data-informed? To the extent we can go from data-informed to data-driven, that's great. But in moving left to right, at least we're starting with a knowledge base of data and information about a problem, using science around risk and protective factors and then saying, "OK, after thinking about community capacity, what are the most likely interventions that will give us a plausible approach to solving a problem?"

Another way to say this is to think about what some people call a *best practices fit*. And here, when we look at the three pieces up top, the *conceptual fit*, we've got some, sort of, almost like a normative expectation about what ought to be done to address a problem. And the practical side is, "Well, what can you realistically do?"

And then, we start thinking about interventions. You're really thinking about obtaining evidence on—that they're going to be working. How do you go about that business? And, I'd say, try to use best-practices fit really is talking about taking what you know the problem is, as you can assess it the best, looking at what's practical in the community in terms of your resources. As we heard, Michigan is—and there are tools, obviously, they use to get a sense of where the local capacity is to address that, and then working towards an effective solution.

Now, the tool that I think is really most important, that I've spent a lot of my—I feel like, life, working on, is having to do with using logic models. Logic models are simply tools. They're really valuable because you can put on a piece of paper exactly what's in the picture, exactly what you really are trying to achieve. Economists: we call them *production functions*. You have *inputs*, you get *outcomes*. In terms of the prevention field, it really is sort of taking that approach of seeing that problem, and we're going to start to think about means to get to a solution.

And so, as we move from left to right in this diagram, you can see, in terms of the problems-related behaviors—that's from the assessment process, which includes the capacity issue in Step 2.

And here we have an example, in that blue box on the bottom on the left, where you

may have identified that you have an increased past month, or 30-day, nonmedical use of prescription drugs. And that's the problem you want to address.

And so, OK, then you ask the question, "Well, how do we go about doing that? And how do we get this done?"

So, in your assessment process, you might have determined in terms of risk and protective factors from the ecological model that there is a problem where there are no clear prescribing guidelines.

You might have been lucky and actually had the veterinarians to come, the dentists to come, the medical community, the acute-care community come in and sort of get a sense of what's going on in terms of prescribing behavior, for example. You also may have had the fortune to have surveys, either from the state, or you conducted locally.

Communities that Care—that was mentioned earlier—they have surveys that help you get at risk and protective factors, for example. There are many other tools out there. But you may discover you have a low perception of harm associated with the nonmedical use of prescription drugs. People don't see using prescription drugs as being dangerous. That's a problem.

So, what interventions did we come up with in this case for this sort of community that we're discussing? Based on the problem, which is increasing use of prescription drugs, they decided to—or at least they could decide—to develop prescribing guidelines. In this case, providing information on consequences. In this case, we're dealing—because of the opiate epidemic out there, we're talking about opiate use.

So, you put this information out in doctors' offices and to share with patients, so they get some understanding about that. And at the same time, the prescribing guidelines might also be informative to the dose we do prescribe. There are a lot of examples now that are starting to emerge where doctors are being encouraged to not give you the 30-day supply of something you only need three days for to use. And in terms of the perceptions of harm, there are two things going on in at least this example: a social marketing campaign.

There's an intervention to target particular populations where you know you have bad news with respect to perceptions of harm. It may be youth: under-age youth who think that using certain medications is just fine because, after all, it comes from the doctor. So, educating them through campaigns about that. And you can make these campaigns very extensive, in terms of saying, "don't use this medicine in combination with some other things," those kinds of things. And, of course, education is really the theme here in terms of—if you have an issue with, in this case, our example of youth, parental education would be to help them understand better the dangers of the

prescription drug, and to make sure that they can pass that information on to their children.

So, the logic model is something that I see as going—in this case, it goes from left to right. It starts with the idea of "we've got a problem."

And I'll spend one more second on this. In terms of the data issues and evaluation parts that come later on in the SPF, if you want to talk about, well, "What's the point of your intervention?"

Well, you look all the way to the left of this diagram: the point is to change that blue box to something that says "decreased the past 30 days nonmedical use."

That's your outcome from the intervention that you're hoping to measure down the road. And these things that you're doing—or these campaigns, these interventions—they're all very measurable. You can talk about the guidelines, you can say where they've been placed, how many people you reached with it, and so on. So, suddenly you've got metrics. And you can start to talk about the logical—use your logic model to design an evaluation tool. And it goes on from there.

So, as you can tell, I'm a big fan of logic models—which probably doesn't make me very popular—but I really do push these, and I think they're very useful tools. And the CAPT has a ton of resources on this stuff to help you through these.

So, let me now move on to potential challenges. Well, the most obvious one is a lot of grant recipients were new to this sort of model, SPF SIG, and may need help in developing logic models, to say, "OK, how do I make this work for us so we can use it as a tool to drive decision making?"

And, of course, in the whole SPF process, to think about what we're trying to achieve from the interventions: so that's one big area. So, finding people who can do that will be beneficial.

Not using local assessment data to drive the process: and that always is a challenge. Sometimes there just isn't any local data in terms of incidence or prevalence of drug abuse, for example, in this case, prescription drug abuse. So, you may have to use external data to the community, which, hopefully, will be data that come from the state, in terms of what we call these prescription drug monitoring programs. At least they can give you some indication that, at least for your state, you can be tied back to your community.

But it's outside the community, and the challenge is how do you go get that? And again, the other part of these logic models is you take this tool and use it to drive the whole, in a sense, strategic plan. So, that's a challenge that we do face. And a couple

more are—and this is sort of a theme of all of ours who do this kind of work is: as we said in that slide with the logic model, having an evaluation plan in place so you can have a feedback mechanism to tell you if things are doing what you expect them to do is also important.

So—and I guess the final point is important in the sense that it's very important in the sense that, when you do this, you just don't do it once: it becomes something that's dynamic, it's ongoing. The sustainability in SPF SIG also really does apply to just keeping that process going with some frequency when you go back and redo the first—all the stops that we talked of so far. I think I overdid my time here in this one, so Michelle, I'm going to turn this back to you.

[Michelle Frye-Spray]: Thanks, John. You're great. Actually, we are just ready to talk about some of your challenges with grantees.

And again, we have another poll here: some different areas for you to respond to in terms of your anticipated challenges related to planning.

Right now, we have a few people who are voting in and weighing in on the experience of developing logic models or strategic plans. I also wonder if one of the challenges might be, you know, the truncated timeframe of trying to get through the process of the strategic framework, compared to what communities used to have, and maybe not understanding the importance of the risk and protective factors. So maybe wanting to skip some steps and, you know, move towards the strategy before really taking that in-depth look at the risk and protective factors.

So if anyone thinks that that might be an issue, put that as an "other" and put that—respond to it in your chat box, if you like.

So right now we have the largest number of you saying really being "the lack of evaluation plan or follow-through."

Yes, another challenge, and, of course, that then relates to: "What are you evaluating?"

And how closely is everything linked, and the underlying assumptions that you're making with that logic model?

Ah. Fernando, yes—backing into strategies. Yes. So, someone sees that as a challenge, as well. And, you know, it's an easy move, default move. But it's like as prevention, you know, practitioners, how can we navigate and mediate our local level communities around that, from doing that? So, I think that there's some great leadership at the state level with the PFS 2015s that can help prevent this.

So, we're moving on to the next section here. And let's take a look at—let's move on here—some potential solutions.

[Dr. John Carnevale]: OK. Here, I'll be brief. In terms of the difficulties in developing evaluations and logic models, I'll just simply note that the CAPT has a substantial amount of resources on these topics that can help you through that process. There are many examples that you can use, in various formats, as a matter of fact, I think. I think the process—certainly, hopefully a lot less painful than it might appear at first.

So, I'll just, because of time, I think I want to make sure that we at least highlight the fact that there are a lot of materials for you—available to you. And we can help with that. The CAPT has access to that information, and they can get that to you.

Early on, I did highlight that there are some new decision-support tools that are about to be released, two of them using—the first one having to do with the understanding influence of increased risk. That's one. And the other one has to do with prevention programming strategies that might apply.

Again, both of these have to do specifically with nonmedical use of prescription drugs. If you note, yes, they're both in the corner on the bottom: they both have a May date, so they'll be coming out very soon and should be available to you to help you get through this process. So, with that, knowing that the time is valuable, I will turn it back to you, Michelle.

[Michelle Frye-Spray]: Thank you very much, John. And, yes, we're going to be excited to roll these tools out to you. You may have seen some previous versions of them, but we can really work with you around tailoring and making sense of these kind of in-depth documents.

I know that one of the early states and early adopters of kind of working with the nonmedical use of prescription drug issue as a prevention priority is the State of Massachusetts. We've learned a lot of lessons from the work that they've done in Massachusetts. And today, we have Fernando Perfas, who is the assistant director of prevention in Massachusetts. He is going to be speaking to us today. Fernando, can you go ahead and unmute your line?

[Fernando Perfas]: Hi, Michelle. Can you hear me?

[Michelle Frye-Spray]: Yes. Yes, welcome.

[Fernando Perfas]: OK, great. Hi. Thank you, Michelle and John, and several others who have spoken already.

You know, honestly, if we had I think 16 Johns that had the same grasp of the logic

model, I think the landscape here in Massachusetts would look a lot different. But unfortunately, that's not the case. And, I think, for those of you who, you know, even just hearing John describe the logic model, I think, for many people, even with the group, that can sound very overwhelming.

And so, for us, we understand that this planning process is a very important step really to kind of synthesize everything that they've gathered in the first two—or everything they've done in the first two phases of the SPF process—to create the strategic plan that's going to guide them through the rest of the grant program. And so, what we do, actually: there are, really, three big things that we do to support the communities around this.

And a lot of it has come about from the lessons that we've learned in previous grant programs, including PFS II, and that's really having dedicated TA support for the programs around the SPF process, really emphasizing what's been said before: identifying gaps in data and capacity. But being deliberate in including that in the strategic plan—so, going beyond just identifying them, and then, you know, and then maybe not doing anything about that. And then, also, revisiting the first three steps of the SPF every year, instead of devoting all this time on the front end of a grant to those three steps, and then maybe never revisiting those steps again. And so, those are really the three main points that I want to talk about really quickly.

And so, going back to the first thing—which I think is one of the most important things we do—is really providing dedicated technical assistance around the SPF to all of our grantees. We have our subrecipients. We have 16 communities that we work with, each with varied understanding of the SPF. And in the past, that's really what we saw as the biggest challenge: really understanding the SPF framework and how that applies to their planning process.

And so, one thing that we've actually done is required that all of our program coordinators take the SAPST training. Oh, man, I can't remember what that stands for—the Substance Abuse Prevention Skills Training—to ensure that they at least have a basic understanding of the SPF before moving into this planning process and, really, in all three steps, all of the first three steps of the SPF.

And so, and each of these communities actually get the dedicated—or actually, let me move back. And so, as far as dedicated TA, we've also been fortunate enough to have the funds to create a dedicated prevention technical assistance center here in Massachusetts. And so, within that center, we have technical assistance staff that is assigned to each of our communities. We don't have 16 separate staff members, but what we do have is the ability to assign a staff person to at least—I think each of the staff people cover about three to four communities. And so, they get dedicated TA

support from this TA center around the SPF and every step of the SPF.

And this planning process is where they receive the most intensive support and guidance from this TA staff, and from this TA center. And we, actually, I know you mentioned before, Michelle, the challenge of trying to do this in a very small period of time or short period of time. And what we've done is we've really tried to give the community as much time as we can to really devote to this planning process. And so, in Massachusetts, that looks closer to about six to eight months, and in some cases, maybe even closer to a year, and really making sure that we devote enough time and attention to each of these three steps before we move forward.

And so, as I said before, we also really—we place a big emphasis on trying to identify the gaps that communities that we work with have in data and capacity. And in the past, that's been difficult because communities generally don't like to talk about that. But we understand that that's generally one of the biggest barriers to this work in those communities. And so we feel that, by addressing that, and then also being deliberate in how we fill those gaps in data and capacity, it allows the communities to really move forward in a way they haven't before.

And so, in some cases, that's part of their logic model, or that's a strategy that they're going to be pursuing. And so, the program's ability to address these gaps has a direct impact on how their strategic plan evolves during the course of the grant period. And what I mean by this is that we revisit the first three steps of the SPF process every year during our site visits. And so, those site visits that we have with communities have actually evolved into more of a planning visit.

You know, the landscape in which we address these issues is constantly evolving. And so, changes in local capacity or access to data, as I mentioned, or changes in political will all have a huge impact on our prevention efforts. So, we feel that our program should be just as dynamic. And so, we put a huge emphasis on the first three steps of the SPF process at the outset of our grants. And we also feel that it's important to revisit that process regularly so that these programs can make the necessary programmatic adjustments or, in some cases, change course completely in an informed and thoughtful way. And so, this makes our site visits—or our planning visits—more productive, and we leverage the opportunity that's presented in having many of the decision-makers in the same room. And, ultimately, we feel it makes these visits more valuable to our subrecipients.

And so, lastly, what I'll say is that all this is guided by sustainability and cultural competence, of course. I appreciate what Larry said before about the difference in culture within hospitals, and that's something that we're continually emphasizing and pushing communities to do as far as defining cultural competence beyond race,

ethnicity, and linguistics. You know, each stakeholder and sector that's involved, there should be involved in this work as a culture that should be understood by our program so that we can frame these issues in ways that they understand and ways that resonate with them, rather than kind of continuing to frame things in a way that we think they should understand them.

And then, as far as sustainability, we feel that that's a conversation needing to happen at the outset of a grant program. In the past—and I guess I'm talking now about lessons learned—we waited till the end. And we found that, if a program can't figure out how an effort can be sustained, it's often too late to start working on that towards the end of the grant period. Time and money is too limited here in Massachusetts, and I'm sure in the rest of the states, to not be having these discussions at the front of the grant. And sustainability is also more applicable to more than just the strategies being implemented: you know, how we access data, how is access to data being sustained, how are the relationships that increase the program's capacity being sustained or maintained so that they can be leveraged for future prevention initiatives is just as important as trying to figure out how to sustain some of these prevention efforts.

[Michelle Frye-Spray]: Thank you so much, Fernando, for bringing us back to those crosscutting principles so eloquently, and how you're thinking about them and modeling it for your grantees in the TA that you're providing. Excellent work.

I hear a lot of fidelity to the SPF, even in this challenging environment of trying to get to the problem and reduce nonmedical use of prescription drugs. But I know that through the process of continuing to delve into the first three steps of the SPF and bringing the subrecipients back to that, that we will get—our states will get to a greater sense of outcomes as well as the states.

And then, there are some questions in the chat box. And I encourage you to share back-and-forth with your colleagues.

We're going to be moving forward here to conclude our workshop today, or our webinar. We so appreciate your participation—you taking time out of your busy day to be with us.

Notice that the webinar is in a PDF format that you can click on and download right here in real time, or we will be sending this out to you at a later time. Please also take a moment to complete the feedback form and tell us how we're doing, the content that you'd like to see in addition to what we presented today. We want to thank our presenters for taking time to put together your thoughts, and for so eloquently speaking to your challenges and successes. Thank you for your generosity.

Thanks to Dr. Carnevale for sharing his expertise, and, as well, the people in the

background who've put this together for us.

We wish you the best afternoon and best of luck as we continue to move forward with the process of preventing nonmedical use of prescription drugs. Until the next webinar: all the best. We'll sign off now. Thank you very much.

[Dr. John Carnevale]: Thanks, everybody.

END OF RECORDING +++